WORLD HEALTH ORGANIZATION

TOBACCO ALERT

OCTOBER 1993

EDITORIAL

The Pan American Health Organization (PAHO) is an active partner in the global "*Fight against the use of tobacco*". The Member States' Regional Committee recognized the need for a commitment to this challenge. In this context, Resolution XXIII* of the Directing Council urged the Organization to promote public health measures at regional and national levels to prevent and control the use of tobacco as well as to protect the health of non-smokers.

The primary objective of PAHO/WHO Regional Office for the Americas (AMRO) health promotion and protection strategies in this regard is to reduce the use of tobacco and tobacco-related health problems through a multi-pronged approach. Specifically, our activities will seek to: a) improve educational programmes for community awareness; b) encourage smoking cessation programmes; c) promote legislation designed to limit smoking in public places; and, d) support other legislative measures which will facilitate and promote a reduction in tobacco use.

In addition to those specific activities, PAHO/AMRO also intends to strengthen its collaboration with governments in the Region, educational and research centres, nongovernmental organizations, and the scientific community, to promote the ultimate purpose of the Regional Plan of Action, namely the creation of societies and generations free from tobacco.

We are aware that smoking is an important public health problem in the Region and is increasingly affecting a wider segment of society. Recent studies indicate that females are becoming more attracted to cigarettes. To this end, multinational tobacco companies are also targeting women and adolescents through increased and specifically tailored advertising and promotion, especially in developing countries.

We believe that most of the achievements pertaining to the reduction of health problems caused by tobacco use, are linked to systematic knowledge-building through research and technology development. The dissemination of further information on tobacco-attributable morbidity and mortality among health science professionals and the public, may be one of the ways of increasing awareness about the need for new initiatives to promote and maintain healthy lifestyles. But more creative health promotion and health education strategies are required in many parts of the Region if there is to be any meaningful result. Its significance is underscored by the fact that an educated consumer can contribute to an overall reduction in demand for tobacco products simply by deciding not to consume them. At the same time, structural and environmental changes will be pursued that complement these educational programmes. However, health education and promotion will only be really effective if they take place in a supportive environment where there is protection from involuntary exposure to tobacco smoke, where tobacco taxes are used to discourage consumption, and where tobacco advertising is prohibited.

PAHO/AMRO intends to give tangible expression to the spirit of the Resolution by forging new links to support a comprehensive public health approach. PAHO/AMRO projects will encourage active community participation at the primary health care level, to implement educational programmes aimed at healthy lifestyles through risk reduction. The challenge to reduce tobacco use and its negative health consequences must remain high among our Regional health priorities and PAHO/AMRO is committed to making a unique contribution to our common goal of building a tobacco-free society.

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* Pan American Health Organization. *Fight against the use of tobacco.* XXIII Meeting of the PAHO Directing Council. Washington, DC, 1988. Information Document CD/33/24.

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EPIDEMIOLOGY

TOBACCO OR HEALTH IN THE AMERICAS

Tobacco consumption already existed in the Americas before the European colonization. Native priests and shamans used it during ceremonial practices to stimulate their spiritual and curative abilities. Tobacco growth as a cash crop started only after European markets were opened during the seventeenth century, and its popularity increased after the US Civil War. Smoking boomed after World War I, and even physicians participated in publicity promoting the addiction in the United States during the post-war period.

Tobacco cultivation shifted from Latin American and Caribbean countries to North America, where the industry dramatically grew for the first half of the twentieth century.

In general, smoking in the Americas decreased during the 1980s. Unlike the decline in the United States and Canada, lower consumption in Latin America and the Caribbean seems to have been based on income elasticity rather than on health concerns. In fact, though *per capita* consumption in Latin America and the Caribbean decreased during the 1980s due to the economic crisis, the upcoming financial recovery and the increase in disposable income is seen to be at the root of recrudescence in smoking in the Region.

In spite of a lack of data and consistent reporting from many countries in Latin America and the Caribbean, the frequency and intensity of smoking can be estimated with some degree of accuracy. Consumption varies among different countries. During the last decade, *adult per capita* use in Cuba, as well as in Canada and the United States, was over 2000 cigarettes per year. The lowest consumption (less than 500 per year) was found in Peru, Haiti, Bolivia and the US Virgin Islands. Other countries in the Region showed rates between these extremes, with a tendency to higher tobacco use in the South Cone and Brazil.

Overall smoking prevalence in the United States and Canada is declining (close to 25% in the United States), and is slightly lower among women as compared to men. Health promotion and education action seem to be having an effect on the population, though interventions are apparently mainly reaching those with a higher level of education.

In Latin American and Caribbean countries, smoking prevalence is much lower among women, and the addiction is more prevalent for urban, and better educated groups. In general, the average tobacco consumption prevalence ranges from 30% to 40% in the Region.

Gender differences in smoking may be disappearing, especially among adolescents and young adults. Recent studies suggest that females are becoming more attracted to cigarettes than males. Smoking used to be culturally unacceptable for women, but recently advertisers have presented the addiction as an issue of women's "equal rights" and liberation. In addition, there is evidence that cessation programmes are less successful among women.

Multinational companies have been very effective in targeting more susceptible and less saturated markets such as women, adolescents, and developing economies. Tobacco companies are increasing publicity and promotion, trying to compensate for rising restrictions and regulations in developed countries.

Even though smoking prevalence declined during the last decade, the starting age for the practice has dropped, the proportion of adolescents, young adults and specially women that begin the addiction has remained unchanged, and the cessation rates are still very low among these groups.

Fortunately, smokers in most countries of Latin America and the Caribbean tend to smoke less cigarettes per day than in the United States and Canada. Recognizing this fact, tobacco companies are trying to modify it through marketing and publicity.

Many governments in the Region have not yet adopted appropriate regulations. There is a general perception among politicians and public officers that tobacco industry stimulates economic growth. In addition, strong pressure from national and multinational companies, foreign governments, interest groups such as farmers and advertisers, and even mass media, make decision makers more hesitant to take action to control the tobacco epidemic.

Cigarette taxes are an important source of revenue for all nations in the Americas. However, tobacco growth and production represent only small percentages of the labour force and cultivated land. On the other hand, the marked increase in lung cancer mortality in the group aged 45 to 64 years, can hardly be attributed to any cause other than smoking. Cardiovascular diseases are also among the first causes of death in all countries. The economic burden imposed by chronic diseases whose development is related to smoking largely exceeds the income that governments obtain from employment and taxes on tobacco.

In general, most countries in the Americas have in place a basic structure to assume a public health approach to tobacco prevention and control. Many have enacted laws designed to limit smoking in public places, tobacco product advertisement, and access to tobacco by young people. However, commonly these initiatives have been insufficiently staffed and funded, and law compliance and enforcement is inadequate. Nevertheless, the presence of these efforts to control tobacco, whether educational or legislative, indicates a favourable environment for changing the current social norms that support smoking. Additional financial and personnel resources, as well as improved data collection are essential to strengthen the actions in the future.

READEX
FICHE

EPIDEMIOLOGY

PROSPECTIVE STUDIES ON THE HEALTH EFFECTS OF TOBACCO IN THE AMERICAS

Although the recent PAHO report on *Tobacco or Health: Status in the Americas* contains estimates for several countries of tobacco-attributable mortality, these are very approximate in view of the lack of detailed data on the health effects of tobacco use in different countries. At best, only indirect estimates can be made using data from countries such as the United States where more specific estimates of relative risk for smokers are available.

Recognizing the urgent need for local studies in developing countries to more reliably document and monitor the evolution of the tobacco epidemic, the World Health Organization, in close collaboration with the University of Oxford in the United Kingdom, has been promoting the implementation of cohort studies. These studies follow up the survival of smokers compared with non-smokers and yield relative risk estimates which take into account the local epidemiological environment. For example, in populations with high average blood cholesterol levels, smoking may be expected to be more cardio-toxic than elsewhere.

A number of countries in the Americas have either begun to carry out prospective studies on mortality due to tobacco use, or are planning to do so. The longest and by far the biggest prospective study is that of the American Cancer Society which has been following the mortality of over 1 million Americans aged 30 years or more since 1982. The results of the first few years of follow-up from this study have been used by the US Surgeon General to estimate smoking-attributable mortality in the United States. Another study has commenced in Mexico City which has enrolled 100 000 households (approximately 200 000 adults). In addition to information on smoking status, blood samples have been taken which should allow much more reliable estimates of the excess cardiovascular disease risk among smokers. In Cuba, a pilot study was carried out in 1992 and the results are being analyzed before implementing a larger prospective study on approximately 300 000 adults. For this study, a standard one-page baseline questionnaire has been developed which seeks information on the respondents' smoking history, alcohol use, blood pressure, height and weight, as well as a brief medical history. The questionnaire exists in both English and Spanish and could be used as a model for similar studies in other countries.

Prospective studies in Brazil (São Paulo) and Argentina (Buenos Aires) are under consideration, and funds to implement them are being sought. It is expected that a first meeting of the global network of prospective studies on the health effects of tobacco will take place in connection with the Ninth World Conference on Tobacco and Health, to be held in Paris in October 1994. This workshop will allow researchers to exchange views on methodological and analytical issues, to present results from their studies, and to develop a common approach to research and analysis.

RECOMMENDATIONS FOR ACTION IN THE REGION OF THE AMERICAS

Based on the information presented in the PAHO Status Report* and the 1992 Report of the US Surgeon General,† the Region of the Americas can build an international coalition against what may be the most important public health issue of the 1990s. Recommendations for action are as follows:

1. Data collection on behaviour, attitudes, knowledge, and beliefs associated with tobacco use should be improved and standardized. These data should be published regularly and used to support changes in public opinion and political action against tobacco use.
2. Data on mortality and morbidity should be improved, collected, and analyzed systematically in nations of the Americas to understand and communicate fully the current and future burden of smoking-related diseases. Without such data, policy-makers and the public will not appreciate the public health burden of tobacco use.
3. Efforts to divert economic and human resources away from dependence on tobacco production and manufacture should be supported, even though short-term costs for this diversion may be appreciable.
4. Policies and legislation that prohibit smoking in public places, advertising and promotion of tobacco products, and access to tobacco by young persons should be strengthened and enforced. These actions serve to decrease the social acceptability of smoking and are essential to changing individual behaviour.
5. Ad valorem taxes on cigarettes should be increased substantially and periodically as a means of decreasing consumption.
6. Public health agencies should mobilize monetary and personnel resources dedicated to the prevention and control of tobacco use. Increasing the stature of tobacco control efforts is essential to changing individual behaviour and preventing chronic diseases associated with tobacco use.
7. Comprehensive, intersectoral and multidisciplinary tobacco prevention and control programmes should be established, including innovative tobacco control activities in schools.

* *Tobacco or Health: Status in the Americas. A report of the Pan American Health Organization.* Scientific Publication No. 536. Pan American Health Organization, Pan American Sanitary Bureau, Regional Office of the World Health Organization.

† *Smoking in the Americas. A 1992 Report of the Surgeon General, in collaboration with the Pan American Health Organization.* US Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Pan American Health Organization, Pan American Sanitary Bureau, Regional Office of the World Health Organization.

COUNTRY PROGRAMMES

ANTI-TOBACCO ACTIVITIES IN LATIN AMERICA: BRIEFS FROM THE FIELD

Action has been taken all over Latin America by Government agencies, non-governmental organizations and other institutions, to reduce tobacco addiction. Some of the activities developed in several countries to help make Latin America tobacco-free are described below.

Brazil: *"Largue o Cigarro Correndo"*

Since 1988, the Ministry of Health of Brazil and other public and private institutions have sponsored an annual foot race with the slogan *"Largue o Cigarro Correndo"* (Run away from smoking). The race receives broad publicity and, in addition to promoting health-seeking behaviour, such as physical exercise, it provides role model stories about local competition winners who have never smoked. More than 400 cities around the country participate in the event every year. The national anti-tobacco programme maintains high visibility both in Brazil and in the international anti-tobacco community.

Costa Rica: School health education

School health education to prevent tobacco use has been included in the anti-tobacco activities of many countries in the Region. In Costa Rica, specific items on the effects of smoking have been included in primary and secondary school curricula. References to smoking as positive behaviour have been eliminated from all textbooks, and material on the health consequences of smoking has been prepared for inclusion in science textbooks.

The Department of Preventive Medicine at the *Caja Costarricense del Seguro Social* (CCSS) carries out preventive public health action in general and, accordingly, has sponsored a number of anti-tobacco educational campaigns and programmes. The CCSS distributes anti-tobacco educational materials in schools and, each year, finances school-based activities and public information campaigns.

Dominican Republic: Getting tobacco out of pharmacies

The Dominican Committee on Smoking and Health has been promoting a campaign to enforce the restriction of tobacco sales in pharmacies. This Committee encourages the community to boycott pharmacies that do not observe the ban, and verifies the activities of the institutions responsible for the surveillance and enforcement of the laws. Through its quarterly newsletter, the Committee provides monitoring results

and denounces businesses that continue to sell cigarettes.

Venezuela: Firm governmental and private support

Since the early 1950s, medical associations have been vocal on tobacco and health issues. Government support has been explicit and firm action has been taken; a noteworthy step has been the suspension of television broadcasting when private channels violated legislation on cigarette advertisement. Since 1979, segregated smoking areas are required on public transportation and in all public places. Cigarette advertising at sports facilities is prohibited, as well as direct and indirect publicity on radio, television, and in public places. The sale of tobacco to minors and in schools and hospitals is also banned.

Since 1987, the Venezuelan Petroleum Company and other companies from the steel and iron industry, support smokers who want to quit, ensure smoke-free workplaces, and provide anti-smoking education for employees and their families. Evaluation of some of these activities has shown a substantial decrease in tobacco addiction among workers and their families.

Venezuela has also pioneered a coherent national anti-tobacco policy, the National Anti-tobacco Programme, which was introduced to curtail the impact of smoking and the diseases associated with tobacco consumption.

PREVENTION

MIRAME! LOOK AT ME!
US OSAP Communication Program Grant
Substance abuse video series for Hispanic youth

In 1990, the US Office of Substance Abuse Prevention (OSAP) established a cooperative agreement with the South Texas Health Research Center of the University of Texas Health Science Center in San Antonio, to produce a cigarette and other substance abuse prevention learning series for 9 to 13 year-old Hispanic youth. The curriculum underwent two years of development and extensive testing.

Mirame is a culturally relevant, theory driven video-based series aimed primarily at low income youth. Learning is facilitated by actual social models which deliver cognitive and behavioral skills enhanced by social reinforcement and support, and self-efficacy. Prevention topics include distinct psycho-social building blocks of adolescent development. Communication design and programme implementation were based on Social Learning Theory. Accompanied by a workbook, each story in the series features real youth handling real problems. The 18-session programme contains five-minute videos, followed by theory and issues for discussion, and a recreational activity (pen and paper exercises and role playing). Issues of form, content and cultural relevance were supported by community advisers, substance abuse experts, communication researchers and members of the target audience. Programme content was thoroughly researched and pretested among Hispanic youth in South Texas.

The experimental programme was delivered through a sample of 40 community-based after-school programmes in San Antonio and South Texas, and a distant learning network targeting selected urban and rural schools subscrib-

CESSATION

INTERVENTION PROJECTS FOR SMOKING CESSATION

Knowledge about the health consequences of smoking has increased considerably since the early 1960s. Attitudes towards the use of tobacco have changed and anti-tobacco policies and programmes have widely proliferated. Consequently, in a few countries of the Americas, almost half of the adults who were ever smokers have now quit. Yet, several million people still smoke and the consumption of tobacco tends to be particularly high among adolescents, blue-collar workers and the less educated. Also the decline in smoking has been slower among women.

Smoking constitutes one of the most important public health problems in this Region where the development of prevention and control programmes is amply justified, and the utilization of effective interventions is urgently needed. Smoking initiation and cessation are dynamic and complex processes that need to be approached at different stages and in many different ways. This is why in the early 1980s, the National Cancer Institute of the United States, through its Smoking and Tobacco Control Program, began to examine intervention methods that included school-based programmes, self-help techniques, health provider delivered interventions, mass-media approaches and community-based interventions. These trials have been regarded as effective and the two experiences that will be briefly described below exemplify attempts to apply these methods in other countries.

Factory workers in Mexico

Although the average per capita consumption of tobacco has been declining in Mexico during the past decade, the 1989 National Survey of Addictions found a prevalence of smoking of 31.2% in the Capital District. This prevalence was even higher among males, mostly single, in the 18 to 29 year-old age group, with low levels of schooling and socio-economic status. Worksites provide easy access to a large number of community residents as they spend several hours each day as a captive audience in their workplace.

The effectiveness of community-wide strategies for smoking cessation, especially among young heavy smokers, has already been assessed by the Community Intervention Trial for Smoking Cessation (COMMIT). Results of this study indicate that these programmes have a favourable impact and also appear to be cost-effective. Therefore, a demonstration project was initiated by the Mexican Institute of Social Security (with the Support of PAHO and the National Cancer Institute of the United States) to reduce the prevalence of smoking in worksites, where nonsmokers are also exposed to the effects of involuntary smoking for several hours a day, over many years.

Two factories in Mexico City, with approximately four thousand workers were selected for this purpose. The overall objective of the project is to reduce the prevalence of smoking among workers and the specific objectives aim at increasing the participation of workers in the achievement of smoke-free policies in worksites, creating incentives to stop smoking and providing information and the services needed to quit. These interventions are being carried out using adapted versions of the materials and methods developed by the COMMIT. The evaluation of this demonstration project includes an environmental assessment and a survey of all workers which will be conducted before and after the interventions are implemented.

The results of this project will provide an opportunity to test existing materials and methods for intervention and to develop and adapt new ones. If successful, these interventions can be emulated for other worksites and for countries with similar conditions.

Health care providers in Chile

Physicians and other health care providers are regarded as valid sources of information on smoking and related health consequences. Since a considerable proportion of the population uses health care services annually, there is an opportunity to involve health care providers, particularly those working in ambulatory primary health care settings, in preventive interventions to modify smoking behaviour.

Results of the COMMIT study have demonstrated that trained health care providers can significantly reduce the prevalence of smoking among their patients, concomitantly with the routine use of clinical interventions. There is also evidence that they can contribute effectively to the implementation of smoke-free policies by health care institutions, and exert positive influence at the community level.

In order to test the feasibility of adapting and transferring these methods to a Latin American environment, an intervention research project was initiated by the Ministry of Health in Santiago, Chile, where most of the population and health care providers are concentrated. The overall goals are to reduce the prevalence of smoking, both among patients and health care providers, and to decrease the social acceptability of tobacco consumption. This is to be achieved by increasing the awareness, motivation and participation of health care providers in smoking cessation activities and in the achievement of smoke-free policies.

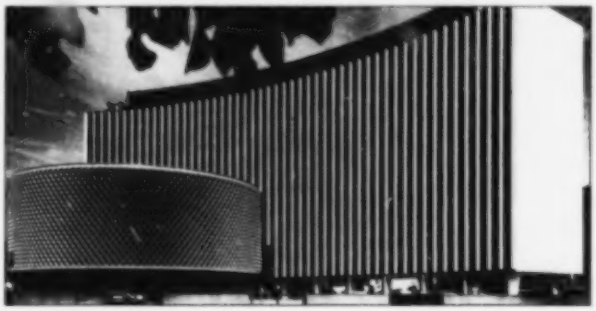
The study includes a survey to be conducted in a sample of health care providers and their patients, before and after the interventions are performed. These interventions include the training of health care providers, provision of printed materials and the implementation of a mass media advocacy effort. Results are expected to be available in the course of 1993, so as to determine further steps in applying these methods.

(continued from page 4)
ing to a nationwide education satellite system. Session presentation was guided by trained local community agency personnel and distant-site school facilitators.

Mirame has been highly accepted and has become an important resource for schools in the south-western region of the United States, where the Hispanic population is considerable. The adoption and/or adaptation of the curriculum to different Latino-Hispanic sub-groups throughout the country is currently under study. This is a very important effort to fulfil the needs of an underserved group that represents the fastest growing minority in the United States.

WHO/TOH PROGRAMME

REGIONAL PLAN OF ACTION FOR PREVENTION AND CONTROL OF THE USE OF TOBACCO IN THE AMERICAS



The Regional Plan has been prepared in response to Resolution XXII*, "Fight against the use of tobacco," of the XXXIII Meeting of the Directing Council of the Pan American Health Organization, that recommended the promotion of public health measures at regional and national levels to prevent and control the use of tobacco as well as to protect the health of nonsmokers.

The ultimate purpose of the plan is to promote the creation of societies and generations free from tobacco. The general objectives are:

1. To cooperate in the development of effective programmes for the prevention and control of smoking in all countries of the Region.

2. To promote the dissemination of the necessary information on the prevention and control of smoking through the establishment of a Regional Information Network.

3. To contribute to the mobilization of public opinion and decision-making centres in order to make the consumption of tobacco socially unacceptable.

To attain these objectives a set of policies and strategies has been determined. PAHO will collaborate with the Member States through their ministries of health, in formulating intersectoral, multi-disciplinary and sufficiently comprehensive policies, plans, and programmes that include legislation (related to consumption, sales, and advertising of tobacco products); education and information; smoking cessation services; and mobilization of public opinion.

In addition, a mechanism of intersectoral coordination should be sought and programmes have to be included in the broader context of changes in lifestyles and of integrated management of risk factors to prevent the most prevalent chronic noncommunicable diseases.

This approach can be summarized in six major strategies:

1. Promotion of the introduction by Member States of policies and programmes for the prevention and control of tobacco use.

2. Collaboration with Member States, centres, and governmental and nongovernmental organizations in identifying and mobilizing resources, with special importance given to public opinion awareness through various initiatives such as mass media, community networks, and the selective effort of social pressure.

3. Fostering the establishment of a regional mechanism to identify, collect, produce, duplicate, disseminate, and evaluate the effectiveness of education and information materials.

4. Cooperation with the governments in the training of personnel involved in the fight against tobacco use.

5. Contribution to the identification, formulation, and execution of applied research necessary for the development of programmes; with particular emphasis on the factors that induce adolescents to initiate consumption, and the efficiency and effectiveness of control programmes.

6. Provision of direct technical advisory services to countries requesting them in order to solve specific problems.

The Plan of Action was discussed and adopted by the XXXIV Meeting of the Directing Council of the Pan American Health Organization in September 1989, after analyzing concerns about its feasibility and applicability. The approving resolution also urged governments to proceed accordingly, and requested the Director of PAHO to mobilize extrabudgetary resources and to collaborate with other agencies to carry out the plan.

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* Pan American Health Organization. Regional plan of action for the prevention and control of the use of tobacco. XXXIV Meeting of the PAHO Directing Council. Washington, DC, 1989. Document No. CD/34/10.

COUNTRY PROGRAMMES

CANADA

In April, 1987, the Canadian Federal Government announced a comprehensive, health-oriented, tobacco control policy that included advertising and product control legislation, as well as administrative and legislative controls on involuntary exposure to tobacco smoke in workplaces, public places and transit vehicles. In addition, taxation policy and economic adjustment assistance to tobacco growers and, of course, health education and health promotion initiatives are also elements of Canada's comprehensive approach. While more tobacco control measures are still being proposed and implemented, many measures to control tobacco smoke, tobacco products and tobacco advertising have been in place since the mid-to-late 1980s. Chief among these were the *Non-Smokers' Health Act* which came into force on 29 December 1989 and the *Tobacco Products Control Act* which came into force on 1 January 1989.

The latter law bans most forms of tobacco advertising and imposes a number of labelling and reporting requirements on tobacco manufacturers and importers. The former law, the *Non-Smokers' Health Act*, controls tobacco use in all areas under federal jurisdiction. Under its provisions, smoking is banned or restricted to just a few designated smoking rooms for 900 000 public and private sector workers under federal jurisdiction, about 10% of the Canadian labour force. Smoking in airports, train stations and trains is limited to a few designated smoking areas. Smoking is banned entirely on all intercity buses and all flights by Canadian air carriers everywhere in the world, with the exception of some trans-Pacific flights.

By the end of the summer of 1988, even before the *Tobacco Products Control Act* had come into effect, each of the three largest tobacco companies had launched separate legal actions to have the law struck down as in violation of the 1982 Canadian Charter of Rights and Freedoms. The core of the Government's defence of the law was that banning tobacco product advertising represents a "reasonable limitation" on freedom of speech, as provided for in Canada's Charter of Rights and Freedoms.

Now, five years after the legal actions were first filed, one case has been held in abeyance and the other two have been heard. Despite the presentation of considerable evidence to the contrary, the judge in the court of first instance

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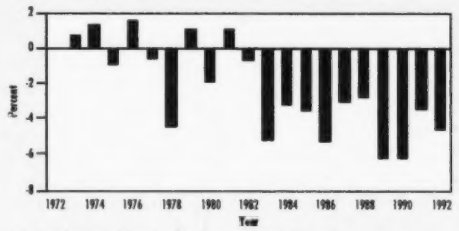
Figure 1
Annual percentage change in number of cigarettes consumed per adult 15+, Canada 1972-1992



Adjusted for smuggling. Total % decrease, 1981-92: -37%

concluded that the control of tobacco advertising and labelling was not a public health measure, but an unfair restraint of trade. This led him to judge that the entire *Tobacco Products Control Act* was invalid. The government then contested this judicial decision on several points, and appealed the matter to a higher court.

At the higher level, the Quebec Court of Appeal, a panel of three senior judges decided the matter in January 1993, ruling the law to be valid. The Court overturned the earlier ruling and decided that it was reasonable for the government to ban tobacco advertising as part of a total strategy to discourage tobacco consumption. The tobacco companies have asked the Canadian Supreme Court for permission to appeal the decision to them, the highest court in the land. Should the Supreme Court grant this request, it would still be several years before such an appeal was decided and the matter brought to a final conclusion.

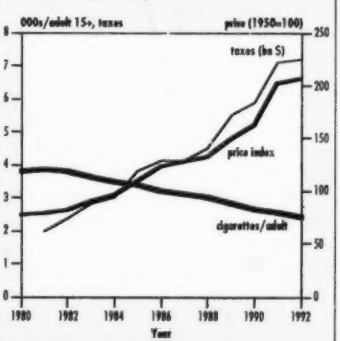
It is important to note, however, that the law has been in force since 1 January 1989 and will remain in force and continue to be respected while the matter is under appeal.

In the light of this favourable ruling from the Quebec Court of Appeal, the government gained renewed confidence in its *Tobacco Products Control Act* and quickly moved to adopt some of the legislative and regulatory measures that had been placed on hold pending a decision from the Quebec Court of Appeal. In March 1993, the Canadian Parliament adopted a new law banning the sale of tobacco products to people under 18 and limiting the placement of cigarette vending machines to bars and taverns. The law will come into force after a coordinated surveillance and enforcement strategy has been worked out with provincial and municipal governments.

On 23 July 1993, the government announced new regulations to amend the health warnings on cigarette packages. Under the new proposal, beginning in August 1994, cigarette packages will have to have one of the eight required warnings, in English on one side of the package and in French on the other. The warnings will occupy 25% of each of the front and back of the package. Half the time they will be in black type on a white background and half the time in white type on a black background in large, bold type.

In 1989, federal tobacco taxes were raised by two cents per cigarette. Several provinces raised tobacco taxes by amounts nearly as large. In 1991, the federal Finance Minister raised federal taxes by a further three cents a cigarette. When announcing the 1991 tobacco tax increases, the federal Finance Minister placed the tax increase firmly in the context of Canada's National Strategy to Reduce Tobacco Use. He went on to state that "The more rapid decline in tobacco consumption in Canada is expected to continue, as the proposed 3-cent per cigarette tax increase will reinforce the government's past actions to curb the use of tobacco in Canada". He also estimated that this measure could be expected to result in 100 000 fewer teenage smokers, and added that he expected the measure to increase tax revenues by CAN$ 1.4 billion in one year. However, to realize these revenue gains, he would have to deal with a growing problem — cigarette smuggling.

Figure 2
Cigarette consumption, prices and taxes in Canada, 1980-1992



1985-1992 consumption data are adjusted for smuggling

As Canadian cigarettes became more expensive in the late 1980s and early 1990s, more and more were exported to the United States, to take advantage of low American taxes or no taxes (at duty-free outlets), and then re-imported back into Canada, mainly through smuggling. This trade was growing exponentially and by 1992 accounted for about 22% of Canadian consumption.

All this smuggling of untaxed cigarettes has cut seriously into governments' revenue expectations, although actual tax revenues are still increasing. A new econometric analysis prepared by the Canadian Department of Finance confirms that Canadian tobacco tax policy has had the desired effects of decreasing smoking, especially among adolescents, while still increasing government revenues. However, the revenue increases were less than forecast because of unanticipated growth in cigarette smuggling.

Public health gains through reductions in tobacco consumption have continued to be realized despite threats to the policy like legal challenges and the growth of widespread smuggling. What is most encouraging is that these gains have been realized particularly among adolescents. Adolescent smoking fell by over 50% from 1979 to 1991. Fewer adolescent smokers now means fewer adult smokers in the future. It also means that, thanks to a ban on advertising, higher tobacco taxes and other tobacco control policies, thousands more Canadian adolescents will live long, healthy and productive lives.

Other measures of tobacco consumption also showed impressive declines in the 1980s and 1990s. Per capita cigarette consumption declined in every year since 1981, with the largest single year decline, 6% in each year, occurring in 1989 and 1990, the two years immediately following the ban on advertising. In all, per capita cigarette consumption decreased by 37% from 1981 to 1992 (**see Figure 1**).

Major increases in the real price was clearly one factor that caused this decline in consumption. Interestingly, even with declining consumption and increased smuggling of tax-free cigarettes, government tax revenues still increased from two billion Canadian dollars in 1981 to over seven billion in 1992 (**see Figure 2**).

Canadian experience has demonstrated that comprehensive tobacco control is possible, and that these policies work together to reduce tobacco consumption.

COUNTRY PROGRAMMES

CUBA*

Tobacco smoking is deeply rooted in the Cuban culture, a fact that is reflected in the high prevalence of smoking. The high level of tobacco use is not so much a product of marketing as it is of strongly entrenched national custom.

Cuba has the third highest death rate from lung cancer in the Americas, and mortality from this form of cancer is reported to be increasing for both men and women, with more than 2600 lung cancer deaths attributed to smoking each year. Mortality from ischemic heart disease is also increasing.

The Cuban Government has recognized the urgent need to prevent and control tobacco use and, since 1960, has prohibited the advertising of tobacco products.

Cuba's statistics on mortality are among the most accurate in the Americas, and its data systems have provided the necessary information for implementing a national tobacco prevention and control programme, officially initiated in 1986. The effects of this programme are measured by such indicators as consumption prevalence, mortality, and the results of knowledge and attitude surveys.

Anti-tobacco interventions have included public information using the mass media, school-based education, legislation, and a public commitment on the part of the Government's leadership to control tobacco use. Studies have shown an increased knowledge of the health consequences of smoking: in a 1988 national survey, 97% of the total population considered themselves "well informed" about the hazards of smoking. Ninety per cent of respondents had received smoking-related information from television, 80% from the radio and 61% from the printed media. The respondents were in favour of policies that restrict smoking in public places, and almost all (98%) supported the newly legislated bans on smoking in enclosed places.

In Cuba, all activities for the prevention and control of tobacco use are carried out within a governmental framework, and it is officially recognized that tobacco has been an important factor in the emergence of noncommunicable chronic disease in the Cuban population. Anti-smoking actions were undertaken in the 1960s, and in 1976, the Ministry of Public Health created the National Commission on Health Promotion, with the stated objectives of reducing sedentary lifestyle, obesity and smoking. In 1986, a national working group, *Grupo de Trabajo Nacional* (GTN), was established to further the anti-smoking campaign. The GTN includes representatives from 15 different government agencies: the Ministries of Health, Education, Higher Education, Culture, Agriculture, Commerce and Transport; institutes concerned with radio, television, aeronautics, sports, physical education, recreation; and different mass organizations.

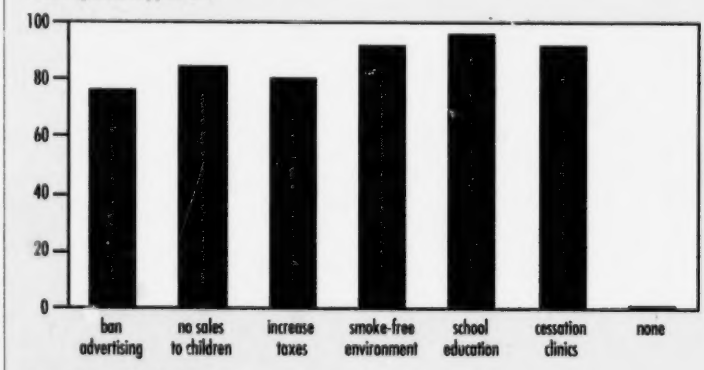
The prevalence of smoking declined by 15.5% during the 1980s but increased among adults aged 30 to 49 years, as well as among women. Between 1974 and 1989, per capita cigarette and tobacco consumption fell by 46.7%, and in 1992, cigarette consumption was reported to have decreased to 1730 per capita. However, even with these reductions the prevalence and consumption of tobacco continue to be high in the Cuban population and there is a need for sustained efforts to further decrease tobacco consumption and tobacco-related disease and mortality.

* Source: *Tobacco or Health: Status in the Americas. A report of the Pan American Health Organization.* Scientific Publication No. 536. Pan American Health Organization, Pan American Sanitary Bureau, Regional Office of the World Health Organization.

URUGUAY: READY TO QUIT

Acknowledging the fact that data on per capita consumption suggest an upward trend in consumption during the last decade, in June 1992, the Ministry of Public Health of Uruguay, supported by WHO/PAHO, conducted a study of knowledge, attitudes and practices concerning smoking and related restrictive measures among 1000 users of primary health care clinics. The survey was part of the National Programme for the Prevention of Lung Cancer, an ambitious plan to test behavioral and medical protective interventions to prevent the development of the disease.

Figure 1
Tobacco control in Uruguay
Public opinion support (%)



Source: Ministry of Public Health

The age of the respondents ranged from 10 to 77 years, with a mean of 33.7 years. Women were slightly more represented than men (52% vs 48%). Almost all the respondents were aware of the dangers of tobacco use, especially lung cancer, obstructive pulmonary disease and cardiovascular disease, and close to 90% mentioned the risks of passive smoking. Ten percent of the sample were former smokers, and nearly all of them quit smoking with no help other than their own will.

A third of the participants smoked six or more cigarettes a day, most of them between the ages of 19 and 40 years. Two-thirds of the smokers started to smoke before the age of 18 years, and more than 20% before 15 years. A significantly higher proportion of smokers were men (49% compared to 32% for women).

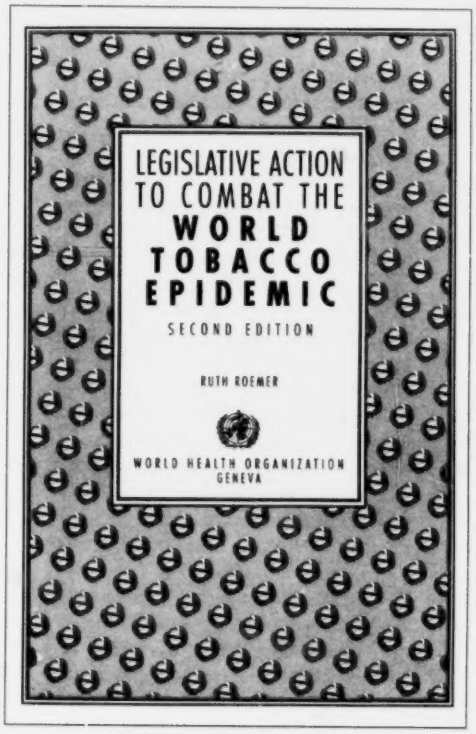
More than three-quarters of those

WHO/TOH PROGRAMME

LEGISLATIVE ACTION TO COMBAT THE WORLD TOBACCO EPIDEMIC

(Second edition) by Ruth Roemer

Following the success of Professor Ruth Roemer's Legislative action to combat the world tobacco epidemic in 1982, her recently published Second edition examines the ways in which legislation — whether involving comprehensive national laws or personal litigation against the tobacco industry — is being used to reduce tobacco consumption and promote the goal of a tobacco-free society. Drawing upon over 250 studies conducted throughout the world, the book concentrates on the many promising new legislative strategies that have developed within a climate of opinion that regards tobacco and sidestream smoke as toxic substances, gives priority to the nonsmoker's rights, and rejects the industry's freedom to promote an addictive, lethal product. By describing and analysing recent legislation, the book also provides a heartening account of both the spread of legislation and the reasons for its increased strength and effectiveness.



The book reflects two main categories of smoking control measures: those leading to changes in the production, manufacture, promotion, and sale of tobacco, and those designed to achieve changes in practice among smokers. On the production or "supply" side, it describes measures involving the control of advertising and sales promotion, the use of health warnings and statements of tar and nicotine content, control of harmful substances in tobacco, restrictions on sales to adults, and economic strategies for decreasing tobacco production. Information is provided on the reasons why legislation is needed, the types of laws that have been enacted in recent years, and the lessons that have been learned. Readers are reminded that voluntary agreements with the industry do not work, that the traditional warning, "Smoking is hazardous to health", is obsolete and no longer effective, and that the best option is total prohibition of all advertising and promotion, including sponsorship of sports events and the arts.

Chapters concerned with controlling demand cover tax and price policies, legislation on smoke-free public places and public transport, legislation on smoke-free workplaces, strategies for preventing young people from smoking, and the use of legislation to mandate health education. Other chapters describe the major types of judicial action that have been used for tobacco control, discuss the special challenge faced in developing countries, and offer advice on how to develop and implement a policy on tobacco control. Six annexes, including an extensive country-by-country tabulation of anti-tobacco legislation, conclude the book.

Issued at a time when several national governments are making quantum leaps forward in the legislative attack on tobacco use, the book should prove especially useful as both a source of encouragement and a practical guide to action.

* Available in English (French and Spanish in preparation) from WHO, Distribution and Sales, 1211 Geneva 27, Switzerland. Order no. 1152202 (Sw.fr. 59.–/US$ 53.10 or developing countries: Sw.fr. 41.30).

(continued from page 8)

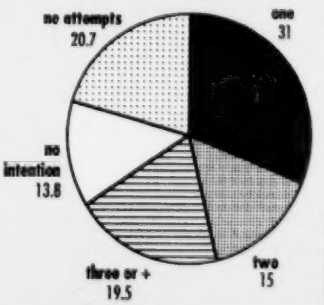
interviewed agreed with anti-smoking initiatives, with school health education and the protection of nonsmokers being high on their list of concerns. Eighty percent approved of increasing cigarette taxes. Young people were more likely to agree with and support tobacco control strategies, a positive sign of generational change in attitude towards smoking.

One of the most interesting findings was the readiness to quit that many smokers showed. Eighty six percent had considered stopping while 77% had made at least one attempt, although only one-quarter maintained abstinence for more than six months. Most of those attempting to quit did so without any sort of external assistance.

In summary, the survey found a significant prevalence of smoking, a high level of awareness of the risks of tobacco use, broad support for restrictive and protective actions, and a considerable number of addicts willing to quit. It was also evident that smokers had received little encouragement or assistance when trying to free themselves of the addiction. According to the study there is an adequate environment to introduce stronger anti-tobacco actions, a need for cessation clinics, self-help materials, and solid social support for quitters.

The National Programme for the Prevention of Lung Cancer in Uruguay has already been initiated, and its short-term and long-term results will make significant contributions to the current body of knowledge.

Figure 2
Readiness to quit among smokers
Uruguay (%): Intentions and attempts



Source: Ministry of Public Health

LEGISLATION

LEGISLATION ON SMOKING CONTROL IN THE AMERICAS

Brief summary

Legislation on smoking control in the Americas might be classified according to its hierarchy in the legal system, and to its content and objectives. In reference to the hierarchy of the norms, principles controlling the smoking of tobacco are, in some instances, contained in constitutions and in health codes which are the highest normative instruments in the legal scale. Regarding its content and objectives, this legislation is aimed mostly at controlling advertising and preventing the use of tobacco for the protection of the "passive smoker". For this purpose, smoking is prohibited in places such as public offices, transportation means, and enclosed recreational areas. Legislation deals also with the creation of advisory bodies for counselling in the formulation of anti-tobacco policies.[1]

Regarding the legal hierarchy of the norms, there is reference to smoking in the Constitutions of Brazil, Ecuador and Uruguay. According to the Brazilian Constitution,[2] commercial advertising of tobacco, as well as other products there mentioned, is subject to legal restrictions and should always warn of the harmfulness of tobacco use. In the case of Ecuador, the reference to smoking control is an indirect one, when the Constitution[3] states that social security as a right of all Ecuadorians, includes programmes intended to eliminate alcoholism and other toxic substances. The Constitution of Uruguay,[4] also refers to the topic when providing that the state is responsible for legislating on all matters relating to health and to combat social vices through laws and international conventions. Aside from constitutional reference, several countries deal with smoking control in their national health codes. This is the case, for example, in Bolivia, Ecuador, El Salvador and Paraguay.[5]

The advertising of tobacco products is regulated through different mechanisms. In some cases there is a total ban on advertising.[6] In others, norms require the provision of adequate information to users on the nature of the product. These norms include prohibitions of cigarette advertising directed at, or referring to, minors under 21 years of age, and advertising that relates to the engaging in sports or physical skills with the use of cigarettes.[7] Norms are also directed at protecting minors in other ways, such as prohibiting radio and television stations as well as theatres, from transmitting advertising of cigarettes during programmes intended for children.[8] Also related to advertising are provisions requiring that labels and wrappings of cigarettes contain warnings indicating the harmfulness of the product to health.[9] By the same token, some norms require that all printed publicity circulated or distributed nationally and referring to tobacco, should include adequate information to users on the nature of the product, such as the average tar and nicotine content of the tobacco.[10]

Legislation has also addressed the protection of the passive smoker, and the prevention of tobacco use. In the first case, there are prohibitions relating to smoke in enclosed areas (hospitals, education establishments and public places), as well as in means of transportation, including domestic flights.[11] The prevention of tobacco use has mainly been addressed in two ways: a) by prohibiting the sale of cigarettes to minors,[12] and b) by establishing preventive programmes and creating councils for health training and education which, in most cases, includes national "non-smoking" days.[13]

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1. References to the Latin American and Caribbean legislation discussed in this summary were extracted from the indexes contained in the LEYES database produced by the Health Policies Program, Division of Health and Development at PAHO/WHO. See also Bolis, M. Frame of reference for analysis of Latin American legislation relating to control of smoking, Health Policies Development Program, PAHO/WHO, Washington, DC, 1989. References to the North American legislation were extracted from Smoking and Health in the Americas. A 1992 Report of the Surgeon General, in collaboration with the Pan American Health Organization. US Department of Health and Human Services. Pan American Health Organization, Regional Office of the World Health Organization.

2. Political Constitution of Brazil, 1988.

3. Political Constitution of the Republic of Ecuador, 10 January 1979.

4. Political Constitution of Uruguay, 1966.

5. Health Code of the Republic of Bolivia, Decree Law No. 15,629 of 18 July 1978; Health Code of the Republic of Ecuador, Decree No. 188 of 4 February 1971; Health Code of the Republic of El Salvador, Decree No. 955 of 28 April 1988; and Health Code of the Republic of Paraguay, Law No. 836 of 15 December 1980.

6. See Canada (Tobacco Products Control Act of 1988, Chapter 20), and Cuba (Ministerial Resolution No. 165 of 17 August 1981).

7. See, for example, Argentina (Secretariat of Trade Resolution No. 422 of 24 May 1984); Bolivia (Health Code); Costa Rica (Decree No. 20,196-S of 30 January 1991); Mexico (Regulation of 16 December 1974); Panama (Decree of the Ministry of Health No. 129 of 19 June 1978); United States (The Comprehensive Smokers Education Act).

8. See, for example, Brazil (Order No. 490 of 25 August 1988); Costa Rica (Decree No. 20,196 of 30 January 1991); Chile (Ministry of Health Circular No. 2C/125 of 10 August 1982); Ecuador (Regulation No. 965 of 13 August 1973); El Salvador (Health Code); and Venezuela (Decree No. 849 of 21 November 1980).

9. See, for example, Argentina (Parliamentary Decree No. 226 of 27 April 1988); Bermuda (The Tobacco Products, Public Health Act, 1987 and the Tobacco Products, Public Health Act, Regulations, 1980); Bolivia (Regulation on the Use of Tobacco, 15 March 1982); Brazil (Regulation No. 731 of the Ministry of Health of 31 March 1990); Colombia (Law No. 30 of 30 January 1986); Costa Rica (Decree No. 20,196-S of 30 January 1991); Chile (Decree No. 106 of 8 April 1981); Ecuador (Regulation No. 965 of 13 August 1973); El Salvador (Health Code); Nicaragua (Decree of 30 June 1976); Peru (Supreme Decree No. 79-70-SA of 1970); United States (the Federal Cigarette Labelling and Advertising Act as amended by the Public Health Cigarette Smoking Act of 1969, The Comprehensive Smoking Education Act of 1984, The Comprehensive Smokeless Tobacco Health Education Act of 1986); Uruguay

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OSH

OFFICE ON SMOKING AND HEALTH

The US Office on Smoking and Health (OSH), a part of the Centers for Disease Control and Prevention, directs the United States Government's tobacco and health activities. It was established in 1978 to inform Americans about the health consequences of tobacco use. OSH also works closely with the World Health Organization as one of the Collaborating Centres on Tobacco or Health.

Among its major domestic activities, OSH develops and distributes the annual Surgeon General's Report on smoking and health; coordinates national public information campaigns with emphasis on prevention messages for teenagers, pregnant women, and minorities (including the "Legends" campaign for African Americans); ensures a proper surveillance system for tobacco use in the United States; maintains a database of about 40 000 scientific articles on tobacco and health; and, for the first time, in 1993, provides funding and technical assistance for US state-based tobacco control efforts. OSH is also working with the US Indian Health Service to establish a comprehensive tobacco control programme for American Indians and Alaskan natives.

Recently, the activities of OSH have taken on a more international flavour. Examples include the 1992 Surgeon General's Report, which focused on the problem of tobacco use in countries of Central and South America; serving as a WHO Collaborating Centre on Tobacco or Health; co-sponsoring the forthcoming All-Africa Conference on Tobacco Control, in Zimbabwe; and participation last year, for the first time, in international trade talks on tobacco between the United States and Taiwan.

OSH is working with Taiwan to help train its experts in using the Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) computer programme, along with investigating SAMMEC's applicability to other countries as well. OSH also releases each year a special issue of the Morbidity and Mortality Weekly Report (MMWR) that ties in with WHO's World No-Tobacco Day. The MMWR of 21 May 1993 contained international reports of smoking cessation programmes from Thailand and the People's Republic of China.

Under the leadership of WHO, OSH was pleased to support WHO in: assisting Nepal with the development of health education materials related to tobacco use, an activity that is expected to expand to a number of developing nations in South-East Asia, including Bangladesh, Thailand and India; developing a multi-media education kit for health education and tobacco use prevention in India; assisting Namibia with the integration of tobacco prevention and control in overall health education and promotion plans, collaborating specifically with the Ministry of Health and Culture and the Ministry of Youth and Sports; co-sponsoring a workshop to address the issue of tobacco use and youth in Barbados; and collaborating with the Professional Services International (PSI) Union to introduce health education into on-going worker education programmes in Zambia.

The international activities of the Office on Smoking and Health in collaboration with WHO, are aimed at achieving overall coordination links with tobacco control forces throughout the world. In addition, these efforts seek to facilitate the development of tobacco control infrastructures in developing countries where the overriding issue is prevention.

(continued from page 10)

(Law No. 15,361 of 24 December 1982), and Venezuela (Tax Law on Cigarettes and Manufacturing of Tobacco of September 1978).

10. See, for example, Ecuador (Regulation No. 965 of 13 August 1973); United States (The Comprehensive Smokeless Tobacco Health Education Act, 1986).

11. See, for example, Bolivia (Regulation on the Use of Tobacco, Decree Law No. 15,629 of 18 July 1978); Brazil (Sao Paulo State Law No. 2,847 of 20 May 1981, Rio de Janeiro Municipal Laws Nos 3,939 of 9 August 1950, 120 of 8 October 1980, and of 1 January 1981, Porto Alegre Municipal Law of 1 January 1981); Canada (Non-Smokers' Health Act, 1988, Chapter 21, Revised Statutes of Canada as amended by Chapter 7, Revised Statutes of Canada, 1988); Colombia (Decree Law No. 3 of the Council for the Special District of Bogota of 3 April 1983, Resolution No. 11,073 of 4 September 1991); Costa Rica (Executive Decrees Nos 17,398-SJ of 21 January 1987 and 17,694 of 13 August 1987); Chile (Order of the Ministry of Health of 11 December 1981); Ecuador (Accord No. 2,369 of 18 June 1992); Guatemala (Governmental Accord No. 681 of 17 August 1990); Peru (Law No. 25,357 of 27 November 1991); United States (The Department of Transportation and Related Agencies Appropriations Act of 1988, Smoking Aboard Aircraft, Parts 121 and 135 of Title 14, Aeronautics and Space, US Code of Federal Regulations); Uruguay (Decree No. 19,067 of the Board of Residents of Montevideo of 14 February 1979, Decree No. 460/983 of the Executive Branch of 6 October 1983, Resolution of 23 September 1976 of the School of Medicine, and Special Service Order No. 3,904 of the Ministry of Health of 9 September 1977); and Venezuela (Resolution No. 512-85, and Ministry of Health Circular of 12 July 1984).

12. See, for example, Colombia (Law No. 20 of 31 January 1986); Costa Rica (Executive Decree No. 17,967-S of 4 February 1988); United States (The Comprehensive Smokeless Tobacco Health Education Act of 1986); and Uruguay (Children's Code).

13. See, for example, Bolivia (Joint Resolution of the Ministries of Social Welfare, Public Health and Education and Culture); Brazil (Law No. 8,389 of 31 December 1991); Chile (Decree No. 1 of 2 January 1986); Ecuador (Accord No. 955 of 10 March 1989 and Regulation of Law No. 15,361, Decree Law No. 263/983 of 22 July 1983); Panama (Resolution No. 1,561 of 17 November 1989); Peru (Ministerial resolution No. 440-88-AS/DM of 5 December 1989); and Venezuela (Decree No. 849 of 21 November 1980).

IARC

MORTALITY PATTERNS OF TOBACCO-RELATED CANCERS IN THE AMERICAS

Tobacco consumption and its health effects have been widely investigated in the USA and Canada; on the other hand, less reliable and complete data are available on smoking-related cancers in Central and Southern American countries.

An analysis has been conducted of the mortality patterns and trends of cancers of the oral cavity and pharynx, oesophagus, larynx, and lung in ten American countries for which accurate data are available.* The figures show age-standardized mortality rates in the mid-1980s for oral and lung cancer, respectively. In both sexes, rates from Uruguay, Cuba and Argentina tend to be among the highest, whereas Panama, Venezuela and Mexico are among the countries with lowest mortality. Mortality rates for cancer of the mouth and pharynx from the USA and Canada are intermediate, but lung cancer mortality in these two countries is higher than those of all remaining American countries. Data on mortality from other cancers of the larynx and the oesophagus closely resemble those shown for the oral cavity. When looking at time patterns since the 1960s, lung cancer mortality has remained stable in Argentina and Cuba, but has strongly increased in both sexes in all other countries considered.

Data on tobacco consumption suggest a wide variation in cigarette smoking among American countries: Cuba, Canada and the USA have the highest consumption while Central American and Andean countries have the lowest consumption. This wide range of values in cigarette consumption is consistent with the range of values for mortality from tobacco-related cancers.

The high variability in lung cancer mortality among American countries might be due in part to bias in death certification, but it is likely to reflect true variability in the effects of tobacco smoking and other carcinogens. A number of case-control studies have been conducted in Latin American countries on tobacco-related cancers; these studies showed that consumption of tobacco products is an important risk factor and that the colour of tobacco is an important aspect of the carcinogenic risk from tobacco smoking in these countries. For example, a study conducted in Cuba reported that male smokers of blond tobacco had a risk of lung cancer of 11 relative to non-smokers, while smokers of black tobacco had a relative risk of 14; a study carried out in Uruguay indicated that smokers of more than 20 black tobacco cigarettes per day had risk of oral cancer of 32 relative to very light smokers, while smokers of the same amount of blond tobacco cigarettes had a relative risk of 21. These studies also showed the carcinogenic effect of diet on the oral cavity, oesophagus, larynx and lung, of consumption of alcoholic beverages on the oral cavity, oesophagus and larynx, and of occupational exposures on the larynx and lung.

On a public health scale, however, it is clear that, whereas cancers of the oral cavity, oesophagus and larynx are a major issue in several Latin American countries, the tobacco-related lung cancer epidemic is still in its early phases in males, and very early phases in females, in these populations. There is, therefore, ample scope for intervention to avoid the spreading of this epidemic in the future.

Figure 1
Mortality rates in selected American countries
Cancer of the mouth and pharynx — Mid-1980s

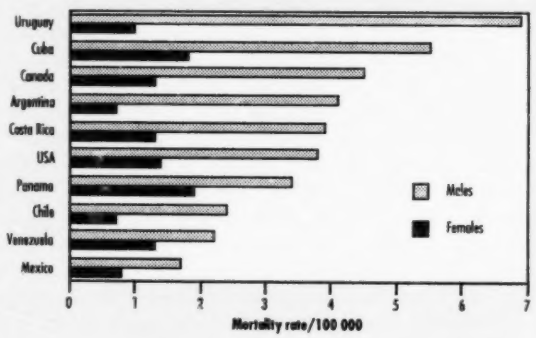
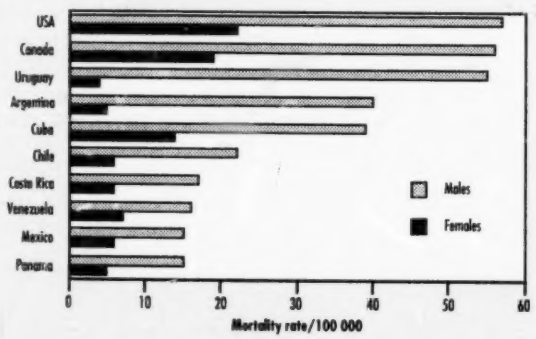


Figure 2
Mortality rates in selected American countries
Cancer of the lung — Mid-1980s



Age-adjusted rates on world standard population

* The full report has been published in the International Journal of Epidemiology 1993; 22: 377-384.

WHO/TOH PROGRAMME

As of 1 July 1993, Dr Claire Chollat-Traquet, the former editor of Tobacco Alert, has been appointed Associate Director of the Cabinet of the Director-General, and is therefore no longer working with the headquarters' Tobacco or Health Programme.

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